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Quarterly Member Services Report

Quarter 1 Fiscal Year 2008



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Introduction

The Quarterly Member Services Report presents a distribution and analysis of complaints for Title XIX/XXI (TXIX/XXI) members receiving behavioral health services in the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) system of care. ADHS/DBHS defines a complaint as, “An expression of dissatisfaction with any aspect of care, other than the appeal of actions.”

Complaints are received by ADHS/DBHS through two reporting mechanisms: the ADHS/DBHS Customer Service Unit and the Regional Behavioral Health Authorities (RBHAs). Complaints may be initiated by eligible and enrolled members, member families or legal guardians, stakeholders (such as the Governor’s Office), other state and RBHA contracted agencies and the public. Complaints received by the ADHS/DBHS Customer Service Unit are referred to the RBHA in which the member is enrolled. RBHAs have systems in place to receive complaint calls directly from the member and through referral by ADHS/DBHS. Complaint data is tracked and trended to identify potential gaps in service delivery, areas for performance improvement and utilized as an integral part of ADHS’ comprehensive Quality Management/Utilization Management Plan.

Complaint categories are standardized by ADHS/DBHS and utilized by the RBHAs in reporting complaint data. The seven complaint categories are:

- Access to Services
- Clinical Decisions Related to Service
- Client Rights
- Coordination of Care
- Customer Service
- Financial
- Information Sharing

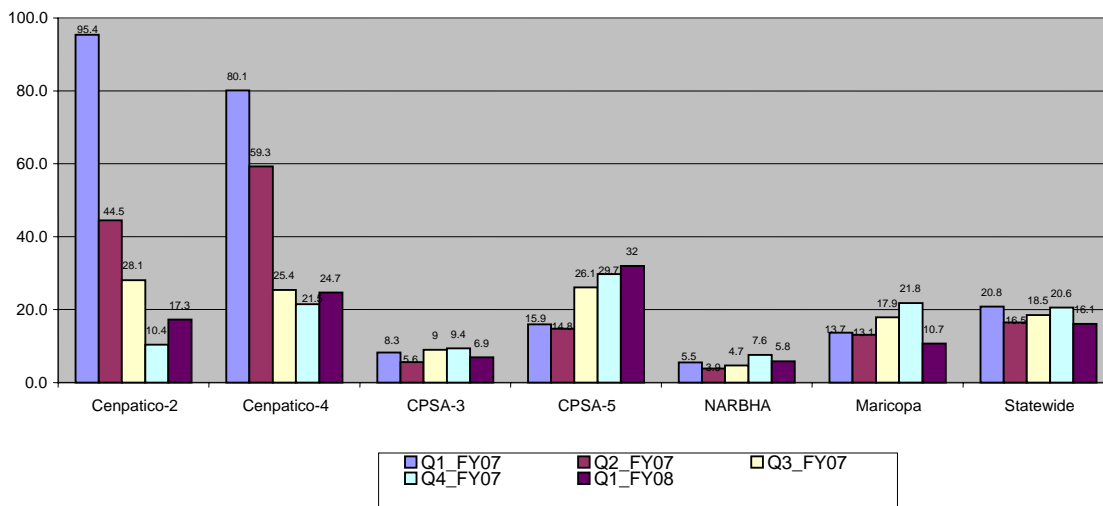
Data Limitations

There are no known data limitations for complaint analysis in Quarter 1, Fiscal Year 2008 (Q108). Data for Maricopa County is represented by two months (July and August, 2007) of complaint data submitted by ValueOptions and one month (September, 2007) submitted by the new Maricopa County vendor, Magellan. In the Q208 Member Services Report, all data provided for Maricopa County will represent Magellan complaints.

Statewide Complaint Rates

This section discusses complaint rates for Q108 per RBHA per 1,000 enrolled members along with a comparison to the complaint rates from Q107. Results are presented in the aggregate by Program Type and RBHA.

Table 1. Complaint Rates per Thousand Title XIX/XXI Members by RBHA
Quarter 1, FY07 –Quarter 1, FY08



As evidenced by the complaint rates per 1,000 in Table 1, complaint rates in Q108 show an overall decrease from the previous four reporting quarters, with the exception of Cenpatico (CBH AZ 2&4) and Community Partnership of Southern Arizona (CPSA) 5 who demonstrated a slight increase in complaint rates this reporting quarter. ADHS/DBHS will request a second level analysis from CPSA and CBH AZ to identify any system issues either positively or negatively impacting the complaint rates.

Table 2 displays the distribution of complaint rates among RBHAs and statewide by Population. Caution should be utilized in interpreting Maricopa County data, as the new RBHA, Magellan, along with ADHS/DBHS, has identified potential data issues in their tracking and reporting of member complaints. ADHS/DBHS has required Magellan to educate front line staff receiving and logging complaint calls to ensure staff are educated on the ADHS/DBHS standardized complaint categories.

	Enrollment			Number of Complaints			Rate per 1,000*		
	Child	Adult	Total	Child	Adult	Total	Child	Adult	Total
Cenpatico-2	1,396	2,946	4,342	32	43	75	22.9	14.6	17.3
Cenpatico-4	2,819	4,422	7,241	87	92	179	30.9	20.8	24.7
CPSA-3	1,308	3,306	4,614	5	27	32	3.8	8.2	6.9
CPSA-5	6,853	13,869	20,722	91	573	664	13.3	41.3	32.0
NARBHA	3,616	8,351	11,967	6	63	69	1.7	7.5	5.8
Maricopa County	15,072	28,817	43,889	94	377	471	6.2	13.1	10.7
Statewide	31,064	61,711	92,775	315	1,175	1,490	10.1	19.0	16.1

When comparing the complaint rate per 1,000 consumers in Q108 to those of FY07, it is evident that the complaint rates for both Adults and Children have remained within statistical controls throughout FY07 to Q108, with the exception of Quarters 1 and 2 of FY07, where CBH AZ demonstrated a significant increase in complaint rates. ADHS/DBHS assisted CBH AZ in targeted improvement efforts to address member

complaints relating to pharmacy benefits. CBH AZ continues to monitor coordination of consumer information into its PBM to quickly resolve system issues impacting member care.

Q108 saw a decline in the Child complaint rate from the previous four quarters. When compared to the statewide enrollment calculations, the statewide Child complaint rate has also remained within statistical controls.

Further analysis of complaint rates reveals that members aged 21 and over lodged the largest number of complaints at a rate of 73% in Q108, indicative of the enrollment numbers for Adults. Adult consumers aged 18-20 lodged only 4% of the total complaints for this quarter, as is consistent with previous reporting. Adult SMI consumers lodged 42% of complaints in Q108, with Adult GMH consumers filing 26% of complaints, followed by Child consumers at 22%. The rate for GMH complaints has dropped as compared to FY07, from 37% to 26%.

Table 3. RBHA/Statewide Adult Complaints by Complaint Category Q108

RBHA	Access to Service		Client Rights		Clinical Decisions Related to Service		Coordination of Care		Customer Services		Financial		Information Sharing		Total	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
CBH 2	10	5.4%	0	0%	3	.6%	23	14%	4	1.6%	2	7.4%	1	6%	43	3.7%
CBH 4	15	8%	5	12%	5	1%	51	31%	13	5.2%	2	7.4%	1	6%	92	7.8%
CPSA 3	6	3.2%	1	2.3%	10	2%	0	0%	9	3.6%	0	0%	1	6%	27	2.3%
CPSA 5	89	48%	12	28%	243	50%	67	41%	143	57%	11	40%	8	44%	573	49%
Maricopa	64	34%	16	37%	202	41%	19	12%	58	2.3%	11	40%	7	39%	377	32%
NARBHA	2	1.1%	9	2.1%	27	5.6%	2	1.2%	22	9%	1	4%	0	0%	63	5.4%
Statewide	186	16%	43	4%	490	42%	162	14%	249	21%	27	2.3%	18	1.5%	1175	100%

Three top complaint categories

The largest numbers of Adult complaints filed by both SMI and GMH members in Q108 were captured in the *Clinical Decisions Related to Services* category (see Table 3). Similar to complaint patterns over FY07, *Clinical Decisions Related to Service* was followed by *Customer Services* and *Access to Services*, rounding out the top three Adult complaint categories this quarter. *Coordination of Care* complaints have continued a downward trend as compared to Q1-Q307, attributed to the decrease in complaints for the previously identified outlier, Cenpatico (CBH AZ). A marked decrease in complaints for Maricopa County is evident in Q108, which may be contributed to the possible data issues identified above. Please see attachments for a complete list of complaint categories and their corresponding sub-categories.

The sub-category contributing to the complaint numbers for *Clinical Decisions Related to Service* is *Assessment/Service Plan Content*, which captures complaints pertaining to the types, frequency and intensity of Covered Services provided to the member as outlined in their individual service plan. *Assessment/Service Plan Content* continues to capture the largest amount of member concerns over FY07 to Q108 and is consistent with the output from various other data sources, such as the ADHS/DBHS Office of Behavioral Health Licensure (OBHL) reviews and subsequent citations; Independent Case Review (ICR)

and Consumer Survey data. ADHS/DBHS has targeted improvement efforts toward assessment and service plan development and maintenance.

The most frequently cited Covered Services related to these types of complaints are *Support Services*, lodged at a rate of 32%, followed by *Treatment Services* at 27%. This indicates a potential issue with treatment planning in Outpatient service settings as well as with services provided in non-traditional settings. To address this issue, ADHS/DBHS' Quality Management Committee referred it to the Clinical Council for review and recommendations. Based on this review, an Assessment/Service Plan workgroup comprised of representation from ADHS/DBHS and the RBHAs was developed to streamline and revise the service plan and assessment templates as well as develop a comprehensive training module to be conducted by ADHS/DBHS at each RBHA.

The second highest complaint category in Q108 is *Customer Service* with the top concern for both SMI and GMH adults being *Unable to Contact Provider Staff*. As this is consistent with Q407 data pertaining to *Customer Service* issues, ADHS/DBHS' Quality Management Committee referred this trend to the ADHS/DBHS Customer Service Department for follow up. *Access to Services* rounds out the top three in terms of categories with the highest complaint rates in Q108.

Medication Services are most frequently complained about in terms of *Access to Care* (please see Table 4). This is consistent with other data reviewed by ADHS/DBHS, such as Urgent Care statistics in Maricopa County which cites "access to psychiatric services" and "need for medication" as top reasons individuals seek its services. As there is a national shortage of psychiatrists, this data is not surprising. To address the lack of treating physicians in Arizona, the RBHAs have completed national searches and hired locum tenems. Another Covered Services category contributing to the complaint rate for *Access to Services* is *Support Services*. ADHS/DBHS has identified this as a network issue and required the RBHAs to include network development for this service in their network plans.

As the RBHAs consistently meet Access to Care standards for initial appointments, this data indicates a potential issue with other aspects of performance, such as office wait times and service authorizations. ADHS/DBHS requires the RBHAs to monitor office wait times to ensure they do not exceed 45 minutes, and monitors this through the Annual Administrative Review. All RBHAs not meeting the standard are required to submit corrective actions. Service authorizations are also reviewed through this process, with actions taken as necessary.

Table 4. Adult Complaints by Covered Service Category, Q108

Covered Service	Access to Services		Client Rights		Clinical Decisions Related to Service		Coordination of Care		Customer Services		Financial		Information Sharing		Total	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Behavioral Health Day Program	0	0%	2	4%	0	0%	1	0%	3	1%	0	0%	0	0%	6	0%
Crisis Services	2	1%	0	0%	11	2%	1	0%	5	2%	1	4%	0	0%	20	1%
Inpatient Services	3	1%	1	2%	25	5%	5	3%	6	2%	5	20%	0	0%	45	3%
Medication Services	75	40%	2	4%	111	22%	11	6%	42	16%	9	36%	2	11%	252*	21%
None Specified	1	0%	0	0%	0	0%	0	0%	1	0%	0	0%	0	0%	4	.3%
Rehabilitation Services	0	0%	0	0%	0	0%	0	0%	2	0%	0	0%	0	0%	2	0%
Residential Services	6	3%	2	4%	48	9%	0	0%	3	1%	0	0%	0	0%	59	5%
Support Services	57	30%	22	51%	160	32%	22	13%	149	59%	2	8%	11	61%	423	36%
Treatment Services	42	22%	14	32%	135	27%	122	75%	38	15%	8	32%	5	27%	364	30%
Total	186	100%	43	100%	490	100%	162	100%	249	100%	25	100%	18	100%	1175	100%

* Top Three Covered Services Categories*

Table 5. RBHA/Statewide Child Complaints by Complaint Category Q108

RBHA	Access to Service		Client Rights		Clinical Decisions Related to Service		Coordination of Care		Customer Services		Financial		Information Sharing		Total	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
CBH 2	7	11%	0	0%	1	.9%	18	20%	6	17%	0	0%	0	0%	32	10%
CBH 4	20	31%	1	33%	10	9%	46	51%	8	23%	1	17%	1	20%	87	28%
CPSA 3	0	0%	0	0%	3	3%	2	2.2%	0	0%	0	0%	0	0%	5	1.6%
CPSA 5	20	31%	0	0%	39	35%	23	26%	7	20%	0	0%	2	40%	91	29%
Maricopa	15	23%	2	66%	57	51%	0	0%	13	37%	5	83%	2	40%	94	30%
NARBHA	2	3%	0	0%	2	1.8%	1	1.1%	1	3%	0	0%	0	0%	6	2%
Statewide	64*	20%	3	1%	112	36%	90	29%	35	11%	6	1.9%	5	1.6%	315	100%

Top three complaint categories

As with Adult complainants, the highest complaint category for Child consumers in Q108 is *Clinical Decisions Related to Service* (Table 5). *Coordination of Care* complaints replaced *Customer Services* as the second highest complaint category, breaking a trend for *Customer Services* complaints over the last two quarters of FY07. Child *Access to Services* and *Coordination of Care* complaints alternated as the third highest complaint category over FY07, with *Access to Services* comprising the third highest complaint category for Children in Q108.

A sub-category analysis of Child complaints indicates *Assessment/Service Plan Content* continues to comprise the majority of Child *Clinical Decisions Related to Services* calls. *Assessment/Service Plan Content* captures complaints pertaining to the types, frequency and intensity of Covered Services provided to the member as outlined in their individual service plan. The Covered Services Category *Treatment Services* was most frequently related to complaints in this category. This Covered Services Category captures complaints pertaining to counseling/therapy; assessment, evaluation and screening and

other professional services. The Assessment/Treatment Plan Workgroup described in the previous section will be addressing concerns related to this topic for the Child population as well.

Applying this level of analysis to *Coordination of Care* and *Access to Services* complaints proves difficult, as no one sub-category for either complaint category occurs at a rate to which one may apply a trend. However, *Coordination of Care* issues identified as an outlier for this complaint category in Quarters 1 and 2 of FY07 lies with CBH AZ pertaining to pharmacy benefit problems with CBH AZ's PBM, US Scripts. ADHS/DBHS QMO reviewed the upward trend in CBH AZ *Coordination of Care* complaints to aid in targeted improvement efforts. ADHS/DBHS QMO identified that pharmacy related complaints are not best captured in the *Coordination of Care* category and should be tracked and trended in the *Financial* Category, sub-category *Entitlements*. Due to the interventions applied to CBH AZ' complaint tracking and reporting, Q108 demonstrated a downward trend in *Coordination of Care* complaint category.

While no identifiable trend has emerged in the sub-categories for the *Access to Services* and *Coordination of Care* complaint categories over the last five reporting quarters, comparison to the Covered Services category, *Treatment Services*, and to the treatment setting from which the majority of Child complaints originated, *Outpatient*, indicates Child consumers are reporting similar concerns to that of Adult complainants, such as the frequency, intensity and duration of Covered Services provided the member as outlined in the assessment and service plan to reach their treatment goals. Table 6 provides a crosswalk of Child complaints as related to Covered Services, presented in the aggregate statewide.

Table 6. Child Complaints by Covered Service Category, Q108

Covered Service	Access to Services		Client Rights		Clinical Decisions Related to Service		Coordination of Care		Customer Services		Financial		Information Sharing		Total	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Behavioral Health Day Program	0	0%	0	0%	1	0%	0	0%	0	0%	0	0%	0	0%	1	0%
Crisis Services	3	4%	1	33%	0	0%	0	0%	0	0%	0	0%	0	0%	4	1%
Inpatient Services	0	0%	0	0%	5	4%	0	0%	0	0%	1	16%	0	0%	6	1%
Medication Services	15	23%	0	0%	13	11%	4	4%	7	18%	3	50%	0	0%	42*	13%
None Specified	0	0%	0	0%	0	0%	0	0%	1	2%	0	0%	0	0%	1	0%
Rehabilitation Services	0	0%	0	0%	4	3%	0	0%	0	0%	0	0%	0	0%	4	1%
Residential Services	2	3%	0	0%	11	9%	0	0%	0	0%	0	0%	0	0%	13	4%
Support Services	12	18%	1	33%	26	23%	8	9%	11	29%	2	33%	4	80%	64	20%
Treatment Services	32	50%	1	33%	52	46%	76	86%	18	48%	0	0%	1	20%	180	57%
Total	64	100%	3	100%	112	100%	88	100%	37	100%	6	100%	5	100%	315	100%

Top Three Covered Service Categories

Complaint Resolution

This section discusses the resolution rates inclusive of Adult and Child members of all program types (Table 8). ADHS/DBHS encourages complaints be resolved at the lowest level possible, striving for resolutions that meet to the complainants satisfaction. The RBHAs have 90 days from receipt of the complaint for resolution.

Table 8. Statewide Complaint Resolutions by Complaint Category, Q108

Resolution	Access To Svc	Client Rights	Clinical Decisions Related to Svcs	Coordination of Care	Customer Services	Financial	Information Sharing	Total
Closed with POC	2	0	14	3	9	0	1	29
Closed w/out Merit	1	1	1	2	2	0	1	8
Pending	59	5	77	75	42	1	6	265
Referred to other Agency	0	0	1	1	0	0	0	2
Referred to Appeal Process	5	14	172	5	17	4	3	220
Resolved	174	22	323	163	207	26	11	926
Resolved w/out Client Satisfaction	7	3	14	1	9	0	3	37
Referred to RBHA QM/UM	0	1	0	0	0	0	0	1
Total	248	46	602	250	286	31	25	1488

Of the 1,488 total complaints received in Q108, 65% were resolved within the reporting quarter. A review of FY07 complaint resolution data indicates this resolution rate is typical for the reporting time frame. Only 18% of complaints are pending resolution in Q108. A review of FY07 resolution data as compared to Q108 data indicates no trend in the remaining complaint resolution categories at this time.

Statewide Appeals

This section discusses the statewide Arizona Health Care Cost Containment System (AHCCCS) appeals rates for TXIX members in Q108. Appeals data is collected by the ADHS/DBHS Office of Grievance and Appeals (OGA). ADHS/DBHS defines an appeal as, "A request for review of an action." "Action" is defined as:

1. The denial or limited authorization of a requested service, including type and level of service;
2. The reduction, suspension, or termination of a previously authorized service;
3. The denial, in whole or part, of payment for a service;
4. The failure to provide a service in a timely manner as set forth in contract;
5. The failure of a contractor to act within the time frames for service as indicated contractually; or
6. For an enrollee residing in a rural area with only one contractor, the denial of an enrollee's request to exercise the right to obtain services outside the contractor's network.

AHCCCS Appeal Rates

AHCCCS appeals rates are aggregated and stratified by RBHA, Program Type, Issue Description and Outcome of Appeals. AHCCCS appeals rates are calculated at a rate per

1,000 enrolled members. Figure 1 reflects the appeals rates for Child and Adult members statewide from FY06 to Q108.

Figure 1. AHCCCS Appeal Rates among Title XIX Members
Quarter 1, FY06 -- Quarter 1, FY08, Statewide

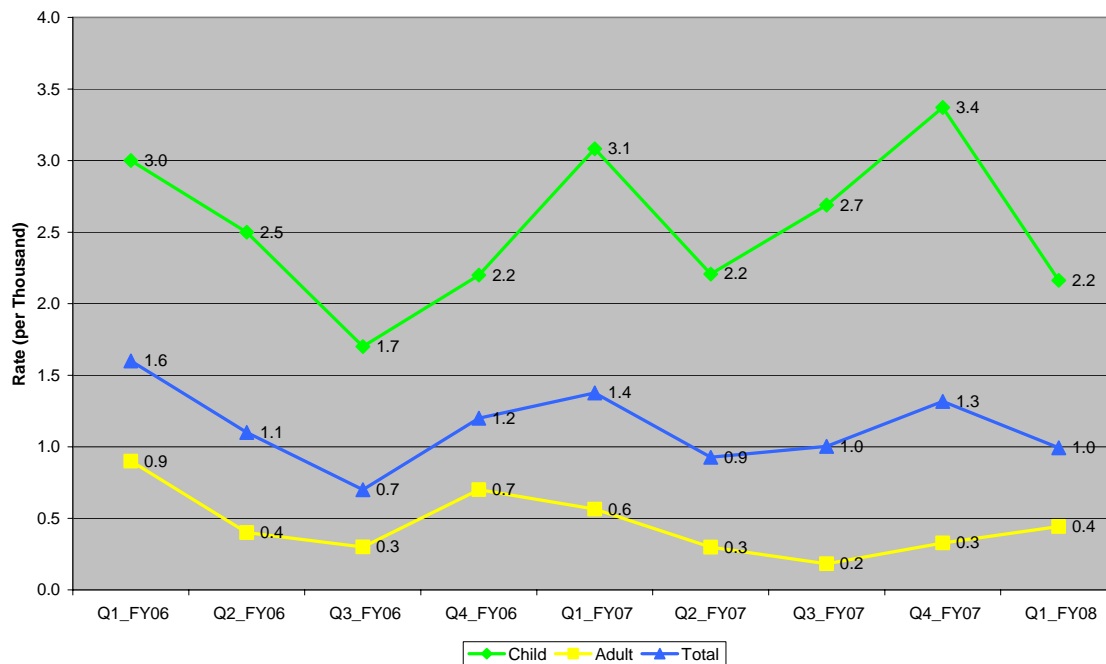


Table 9. Appeals* Rates among Title XIX Members by RBHA, Q108

RBHA	Number of Appeals			Rate**		
	Child	Adult	Total	Child	Adult	Total
CBH 2	0	0	0	0	0	0
CBH 4	6	0	0	2.3	0	0.9
CPSA 3	2	3	5	1.6	0.9	1.1
CPSA 5	4	9	13	0.6	0.7	0.6
Maricopa	48	12	60	3.5	0.4	1.4
NARBHA	2	3	5	0.6	0.4	0.4
Statewide	62	27	89	2.2	0.4	1.0

*AHCCCS Appeal

**Per 1,000

During Q108, ADHS/DBHS OGA documented a total of 89 appeals for TXIX members at a rate of 1.0 per 1,000, a decrease from Q107 (1.4 per 1,000). As appeals rates can mirror the increase or decrease in complaint rates, the lower overall complaint rate in Q108 is reflected in the decreased appeals rate for this reporting quarter. Appeals filed on behalf of Child members has remained the outlier for the increase or decrease in appeals rates from FY06. Appeals for this population are related primarily to denial of out-of-home placements, particularly residential treatment centers, and are originated by system partners as opposed to caregivers or families.

Program Type

Table 10 displays the distribution of Q108 appeals by Program Type.

Table 10. Appeals among Title XIX Members by Program Type, Q108

Program	Frequency	Percent
Children	62	69.66%
GMH/SA	16	17.98%
SMI	11	12.36%
Total	89	100.00%

Issue Description

Table 9 displays the distribution of Q108 appeals by Appeal Issue Description. *Denial of Service* appeals have begun a downward trend from Q307 to Q108 (90% of appeals to 77.53%). However, this appeal description comprises the majority of member filed appeals.

Table 11. Distribution of Appeal among Title XIX Members by Issue Description, Q108

Issue Description	Frequency	Percent
Denial of Service	69	77.53%
Reduction, Suspension or Termination of Service	11	12.36%
Timeliness of Service	1	1.12%
Denial of Claim Payment	1	1.12%
Denial of Service Outside Network	7	7.87%
Total	89	100.00%

Outcome of Appeals

Table 10 represents the distribution of TXIX appeals by Appeals Outcomes. Per an identified upward trend in the Appeals Outcome, *Decision Overturned, RBHA*, from Q2-Q407, this Appeals Outcome category has been further stratified by RBHA and Program Type (Table 12). However, it appears that *Decision Overturned, RBHA*, is now on a downward trend starting in Q108, from 49% in Q207 to 48.78% in Q407 with 27.78% of appeals outcomes in this resolution category this reporting quarter.

Table 12. Distribution of Appeals among Title XIX Members by Outcomes, Q108

Outcome	Frequency	Percent
Decision Overturned (RBHA)	25	27.78%
Dismissed, Not an Action (RBHA)	24	26.67%
Decision Upheld (RBHA)	18	20%
Withdrawn (RBHA)	15	16.67%
Compromise (RBHA)	5	5.56%
Dismissed, Improper Filing Party (RBHA)	1	1.11%
Dismissed, Failure to Appear (RBHA; Hearing Level Only)	1	1.11%
Dismissed, Other (RBHA)	1	1.11%
Total	90	100%

Table 13. Distribution of “Decision Overturned, RBHA,” by RBHA and Population

Process Description	RBHA	Frequency	Percent
RBHA TXIX/TXXI Appeal -SMI	NARBHA	1	4.0%
RBHA TXIX/TXXI Appeal - Child	NARBHA	1	4.0%
RBHA TXIX/TXXI Appeal - Child	Cenpatico-4	4	16.0%
RBHA TXIX/TXXI Appeal - Child	Maricopa County	18	72.0%
RBHA TXIX/TXXI Appeal - GMH/SA	Maricopa County	1	4.0%
Total		25	100.0%

While Maricopa County represents 72% of this appeals outcome, only 18 total appeals comprised this outcome category. ADHS/DBHS OGA continues to monitor outcomes of appeals for targeted areas of improvement.

Conclusion

ADHS/DBHS utilizes quarterly complaint data to identify system wide areas for improvement and incorporate member feedback into ongoing service delivery. ADHS/DBHS QMO continues to monitor the Covered Services and Complaint Sub-Categories informing the overall complaint rates in order to target improvement efforts to specific RBHAs and their sub-contractors to improve performance statewide. ADHS/DBHS QMO is actively researching industry data to identify standards in complaint reporting and any benchmarks or thresh holds to apply in statistical analysis, utilizing data provided by the National Benchmarking Association’s Best Practice Roundtable on Complaint Handling Process Benchmarking Study, results of which will be provided to ADHS/DBHS as they are yielded.

Appendix A

COMPLAINT CATEGORY	COMPLAINT SUB-CATEGORY	DEFINITION
Access to Services	No Provider to Meet Needs	Concern that the ability to receive a service occurred as a result of the lack of a provider to meet the specific needs of the client.
	Wait List	Concern that the service is not provided within an appropriate time frame due to provider capacity issues.
	Timeliness	Concern that the service was not offered/provided within the required timeframe.
	Office/Appointment Wait Time	Concern that the wait time for a scheduled appointment exceeds the maximum wait time as identified in the Provider Manual (45 minutes).
	Enrollment	Concern that the ability to obtain medication or access a service is related to the enrollment process.
	Authorization Process	Concern about prior-authorization for services/medications; or inability to access a service in a timely manner due to a lengthy prior authorization process.
Clinical Decisions Related to Service	Denial of Service	Concern relating to a decision to deny a TXIX/TXXI request for a prior authorized new service. For SMI, could be NTXIX.
	Reduction, Suspension, or Termination of Services	Concern relating to a decision to reduce, suspend or terminate a current TXIX/TXXI covered service. For SMI, could be NTXIX
	SMI Eligibility	Concern relating to the decision that an applicant does not meet the SMI eligibility criteria.
	SMI De-certification	Concern relating to the decision that an SMI member no longer meets the SMI eligibility criteria.
	Assessment/Service Plan Content	Concern relating to the developed plan that identifies the goals and outcomes for behavioral health services and/or issues with treatment and discharge planning. In addition, concerns specific to types, quality, and frequency of covered services received or not received as well as those relating to the consumers voice related to concerns.
	Lack of Service Plan	Concern that an enrolled client does not have a service plan developed within the required timeframes.
	Diagnosis	Concern that a client has been identified with incorrect diagnosis
	Medications	Disagreement with medication regimen.
	Court Ordered Treatment	Disagreement with a decision to pursue a court order; or related to a denial of a COE request.
	Cultural Issues	Concerns that a client has received services inconsistent with cultural preferences or needs.
	Concern about client's well-being	Call from client or other, identifying concern due to increase in symptoms and / or functional impairment.
Client Rights	Confidentiality	Concern relating to the failure to meet the privacy requirements of behavioral health information.
	Restraint/Seclusion	Concern about the use of restraint and seclusion.

	Sexual Abuse	Concern that staff of a mental health agency engaged, or allowed another person to engage, in sexual misconduct with a client.
	Physical Abuse	Concern that staff of a mental health agency through act or omission, inflicted or allowed another person to inflict, physical pain or injury on a client.
	Exploitation	Concern that staff took advantage, or allowed another to take advantage, of a client or a client's resources for profit or gain.
	Mistreatment	Concern of staff neglect or other ill treatment. (Not to include abuse or exploitation.)
	Verbal Abuse	Concern that staff, as a result of a verbal communication to the client, expose a client to risk of emotional harm. (ie. Threats, belittling, name calling or yelling.)
	Dangerous Condition	Concern that a condition exists that poses a danger to the health or safety of a client.
	Other - Rights Violation	Catch all for any other client rights violation not otherwise specified.
	Unlawful Conduct by a Provider	Concern involving unlawful conduct of a provider.
	Mortality	Concern relating to the death of a client.
	Lack of Required Notice	A denial, reduction, suspension or termination of service has occurred, but client was not provided with required Notice.
	Service Contingency	Client was informed that receipt of one service is contingent on participation in another service.
Coordination of Care	Coordination Between Health Care Systems	Concern related to who is responsible for providing or paying for a specific service.
	Continuity of Care	Concern of failure to ensure the client's smooth transition between levels of care and agencies or the coordination of services between other state agencies and providers
	Inter-RBHA Transfer	Concern of failure to ensure the client's smooth transition in event of an Inter-RBHA Transfer. Concern that requirements in Transition of Persons Provider Manual Section is not followed.
	Intra-RBHA Transfer	Concern of failure to ensure the client's smooth transition in event of an Intra-RBHA (between RBHA sub-contracted providers) Transfer.
	MMA Issues	Concerns related to medication complications involving the Medicare Modernization Act.
	Prior Authorization	Concern that prior authorization was required for a service for which prior authorization should not be required; lack of timely completion of the prior authorization process when appropriate to use prior authorization.
Customer Service	Unable to contact RBHA staff / not receiving return calls	Concern that attempts to contact a RBHA staff are unsuccessful; concern that phone messages are not returned.
	Unable to contact Provider staff/not receiving return calls	Concern that attempts to contact a Provider staff are unsuccessful; concern that phone messages are not returned.

	Needs information about services / procedures	Calling to obtain information about covered services / procedures that should have been provided through the assigned provider/clinical team.
	Appointment Cancelled Without Notice	Concern that a scheduled appointment was cancelled without adequate notice to the client
	Flexibility of Agency Service Hours	Concerns that services are not offered with flexible hours (no service availability outside routine business hours)
	Staffing Pattern	Complaint about insufficient staffing or high turnover with staff.
	Other - No Rights Violation	Catch all for generalized complaints that do not constitute a rights violation including consumer belief that they were not treated respectfully.
Financial	Fees/Co-pays	Concern relating to assessed fees and co-pays to the client for behavioral health services.
	Claims	Concerns by provider / insurance carrier regarding claims.
	Billing	Concerns by client/guardian that they have been inappropriately billed for services.
	Claim Payment	Concern of a provider relating to the payment for services (non-payment; incorrect payment; denial).
	Entitlements	Concern that a person is not receiving services because they do not fall into an entitled category (SMI, TXIX/XXI).
Information Sharing	Request for Medical Records	Concerns that client/guardian has requested, but not received, medical records.
	Family Involvement	Concerns that family members are not involved in treatment; families are concerned that they cannot get information about the enrolled client.
	Restrict Access to Health Information	Request to restrict access to health information.

*The most updated complaint category 2/14/06

POLICY GA 3.6 COMPLAINT RESOLUTION

- A. PURPOSE: To establish the process for T/RBHAs and ADHS/DBHS to ensure the resolution and tracking of complaints reported by eligible and enrolled persons, their families, or legal guardian(s), authorized representatives, other agencies and the public.
- B. SCOPE: ADHS/DBHS and T/RBHAs.
- C. POLICY: ADHS/DBHS and T/RBHAs shall:
- Respond to all complaints consistent with the requirements contained herein; and
 - Track complaints for use as a source of information for quality improvement of the behavioral health service delivery system.

General questions or requests for information shall not be considered complaints.

An action that is subject to appeal through the Title XIX/XXI Member Appeal process shall not be handled as a complaint; rather, must be responded to as an appeal pursuant to ADHS/DBHS Policy and Procedure GA 3.3, Title XIX/XXI Notice and Appeal Requirements.

- D. REFERENCES: [42 CFR § 431.200 et seq.](#)
[42 CFR § 438.210](#)
[42 CFR § 438.400 et seq.](#)
[9 A.A.C. 34, Article 2](#)
[AHCCCS/ADHS Contract](#)
[ADHS/RBHA Contracts](#)
[ADHS/TRBHA IGAs](#)
[ADHS/DBHS Policy and Procedure GA 3.3, Title XIX/XXI Notice and Appeal Requirements](#)

E. DEFINITIONS:

1. Complaint – An expression of dissatisfaction with any aspect of care, other than the appeal of actions.
2. Health Care Professional – A physician (allopathic or osteopathic), licensed

POLICY GA 3.6 COMPLAINT RESOLUTION

psychologist, physician assistant, registered nurse (including nurse practitioner), licensed independent social worker, licensed marriage and family therapist and licensed professional counselor.

F. PROCEDURES:

1. T/RBHA Requirements for Handling Complaints

- a. Each T/RBHA shall establish a centralized complaint resolution process for their region, and designate an individual, or individuals, to whom all complaints shall be referred. The individual (or individuals) must be trained to distinguish a complaint from a Title XIX/XXI appeal of an action (See ADHS/DBHS Policy and Procedure GA 3.3, Title XIX/XXI Notice and Appeal Requirements). Persons seeking or receiving behavioral health services should always be encouraged to resolve issues at the lowest possible level. However, each T/RBHA must ensure that persons are aware that complaint and appeal processes are also available when necessary.
- b. The responsibilities for resolving complaints pursuant to requirements of this policy shall not be delegated by the T/RBHA. This does not preclude behavioral health providers from problem solving identified issues with behavioral health recipients.
- c. The T/RBHA shall respond to all complaints according to the requirements contained in this policy.
- d. In the event that the T/RBHA receives a complaint referred from ADHS/DBHS, the T/RBHA will provide a written summary to ADHS/DBHS that describes the resolution of the complaint within the timeframe specified by ADHS/DBHS.
- e. The T/RBHA shall ensure that any specific corrective action or other action directed by ADHS/DBHS is implemented.
- f. When information is received, either orally or in writing, that the individual has a limited English proficiency or other communication need, the following requirements apply:
 - (1) For individuals needing translation in the prevalent non-English language within the region, the T/RBHA shall provide a written translation of any

POLICY GA 3.6 COMPLAINT RESOLUTION

information.

- (2) For individuals who need translation in a language that is not considered a prevalent non-English language within the region or who require alternative formats (such as TTY/TTD), the T/RBHA shall provide oral interpretation or make alternative communication formats available, as indicated.
- g. Complaints may be made orally or in writing by eligible and enrolled persons, their families or legal guardian(s), authorized representatives, other agencies or the public to the T/RBHA. The T/RBHA shall not route, or otherwise encourage, the direct filing of complaints with AHCCCS, unless the person is AHCCCS or ALTCS eligible and enrolled and the complaint is specific, or directly relates, to the acute care health plan/provider.
- h. The T/RBHA shall establish and make available a toll free telephone number that can be used to file oral complaints.
- i. The T/RBHA shall acknowledge, either in writing or orally, the receipt of each complaint within 5 working days to the complainant.
- j. The T/RBHA must provide a decision to the person complaining as expeditiously as the health condition affected requires; however, T/RBHAs are required to dispose of each complaint and provide oral or written notice within a timeframe that does not exceed 90 days.
- k. The T/RBHA shall ensure that:
 - (1) Individuals who make decisions regarding complaints are not involved in any previous level of review or decision-making; and
 - (2) The individuals who make decisions about a complaint regarding the denial of expedited resolution of an appeal or complaint involving clinical issues are health care professionals with the appropriate clinical expertise in treating the behavioral health recipient's condition.
- l. The T/RBHA shall:

POLICY GA 3.6 COMPLAINT RESOLUTION

- (1) Maintain a log of all complaints received, utilizing a set of fields (see Attachment A), which documents the following information:
 - (a) The behavioral health recipient's first and last name;
 - (b) The date the complaint was made;
 - (c) Title XIX/XXI eligibility status;
 - (d) The source of the complaint;
 - (e) A description of the complaint;
 - (f) Any identified communication need (e.g., need for translator);
 - (g) The outcome reached;
 - (h) The length of time for outcome, as indicated in Section F.1.j. of this policy;
 - (i) Covered service category;
 - (j) Treatment setting; and
 - (k) Behavioral health category.
- (2) Routinely review the data collected through the complaint process as part of the T/RBHA's quality improvement strategy and network sufficiency review.

2. ADHS/DBHS Requirements for Handling Complaints

- a. In the event that complaints are received by ADHS/DBHS from eligible or enrolled persons, their families or legal guardian(s), authorized representatives, governmental entities, other state agencies, private agencies and the public, the complaint will be referred to the appropriate T/RBHA staff designated to respond to complaints and according to the protocol established with the T/RBHA and the process described in Section F.1. of this policy.

POLICY GA 3.6 COMPLAINT RESOLUTION

- b. ADHS/DBHS staff shall enter information regarding complaints into the automated ADHS/DBHS complaint database.
- c. ADHS/DBHS shall routinely review the data collected through the complaint process as part of its quality improvement strategy.

G. APPROVED BY:

Eddy D. Broadway	Date
Deputy Director	
Arizona Department of Health Services	
Division of Behavioral Health Services	

Attachment A

Complaint Log Fields and Categories

a. The behavioral health recipient's first and last name		
b. The date the complaint was made		
c. Title XIX/XXI eligibility status:		
Yes		
No		
d. The source of the complaint:		
ADC (Arizona Department of Corrections)		
ADE (Arizona Department of Education)		
ADJC (Arizona Department of Juvenile Corrections)		
Adult Probation/Court		
Advocate – Other		
AOC (Administrative Office of the Court)		
JPO (Juvenile Probation Office)		
Attorney		
Arizona Center for Disability Law		
Consumer Run Groups		
DBHS		
Designated Representative		
DES-ACYF/CPS		
DES-DDD		
Family Member Other than Parent		
Friend		
Health Plan		
Non-Custodial Parent		
Office of Human Rights		
Other		
Parent/Legal Guardian		
Provider		
Self (age 18 and over)		
e. A description of the complaint:		
Category	Subcategory	Definition*
Access to Services	No Provider to Meet Needs	Concern that the ability to receive a service occurred as a result of the lack of a provider to meet the specific needs of the client.
	Wait List	Concern that the service is not provided within an appropriate time frame due to provider capacity issues.
	Timeliness	Concern that the service was not offered/provided within the required timeframe.

*Definitions do not need to be included on the complaint log.

Last revised: 05/01/2006

	Office/Appointment Wait Time	Concern that the wait time for a scheduled appointment exceeds the maximum wait time as identified in the Provider Manual (45 minutes).
	Authorization Process	Concern about prior-authorization for services/medications, or inability to access a service in a timely manner due to a lengthy prior authorization process.
Clinical Decisions Related to Service	Denial of Service	Concern relating to a decision to deny a TXIX/TXXI request for a prior authorized new service. For SMI, could be NTXIX.
	Reduction, Suspension, or Termination of Services	Concern relating to a decision to reduce, suspend, or terminate a current TXIX/TXXI covered service. For SMI, could be NTXIX.
	SMI Eligibility	Concern relating to the decision that an applicant does not meet the SMI eligibility criteria.
	SMI De-certification	Concern relating to the decision that an SMI member no longer meets the SMI eligibility criteria.
	Assessment/Service Plan Content	Concern relating to the developed plan that identifies the goals and outcomes for behavioral health services and/or issues with treatment and discharge planning. In addition, concerns specific to types, quality, and frequency of covered services received or not received as well as those relating to the consumers voice related to concerns.
	Lack of Service Plan	Concern that an enrolled client does not have a service plan developed within the required timeframes.
	Diagnosis	Concern that a client has been identified with incorrect diagnosis.
	Medications	Disagreement with medication regimen.
	Court Ordered Treatment	Disagreement with a decision to pursue a court order; or related to a denial of a COE request.
	Cultural Issues	Concerns that a client has received services inconsistent with cultural preferences or needs.
	Concern about Client's Well-being	Call from client or other, identifying concern due to increase in symptoms and/or functional impairment.
Client Rights	Confidentiality	Concern relating to the failure to meet the privacy requirements of behavioral health information.
	Restraint/Seclusion	Concern about the use of restraint and seclusion.
	Sexual Abuse	Concern that staff of a mental health agency engaged, or allowed another person to engage, in sexual misconduct with a client.
	Physical Abuse	Concern that staff of a mental health agency through act or omission, inflicted or allowed another person to inflict, physical pain or injury on a client.
	Exploitation	Concern that staff took advantage, or allowed another to take advantage, of a client or a client's resources for profit or gain.

*Definitions do not need to be included on the complaint log.

Last revised: 05/01/2006

	Mistreatment	Concern of staff neglect or other ill treatment. (Not to include abuse or exploitation.)
	Verbal Abuse	Concern that staff, as a result of a verbal communication to the client, expose a client to risk of emotional harm. (i.e., Threats, belittling, name calling or yelling.)
	Dangerous Condition	Concern that a condition exists that poses a danger to the health or safety of a client.
	Other - Rights Violation	Catch all for any other client rights violation not otherwise specified.
	Illegal	Concern of an incident that has occurred that violates the law.
	Mortality	Concern relating to the death of a client.
	Lack of Required Notice	A denial, reduction, suspension or termination of service has occurred, but client was not provided with required Notice.
	Service Contingency	Client was informed that receipt of one service is contingent on participation in another service.
Coordination of Care	Coordination Between Health Care Systems	Concern related to who is responsible for providing or paying for a specific service.
	Continuity of Care	Concern of failure to ensure the client's smooth transition between levels of care and agencies or the coordination of services between other state agencies and providers.
	Inter-RBHA Transfer	Concern of failure to ensure the client's smooth transition in event of an Inter-RBHA Transfer. Concern that requirements in Transition of Persons Provider Manual Section is not followed.
	Intra-RBHA Transfer	Concern of failure to ensure the client's smooth transition in event of an Intra-RBHA (between RBHA sub-contracted providers) Transfer.
	Prior Authorization	Concern that prior authorization was required for a service for which prior authorization should not be required; lack of timely completion of the prior authorization process when appropriate to use prior authorization.
Customer Service	Unable to contact RBHA staff/not receiving return calls	Concern that attempts to contact a RBHA staff are unsuccessful; concern that phone messages are not returned.
	Unable to contact Provider staff/not receiving return calls	Concern that attempts to contact a Provider staff are unsuccessful; concern that phone messages are not returned.
	Needs information about services/procedures	Calling to obtain information about covered services/procedures that should have been provided through the assigned provider/clinical team.
	Appointment Cancelled Without Notice	Concern that a scheduled appointment was cancelled without adequate notice to the client.
	Flexibility of Agency Service Hours	Concerns that services are not offered with flexible hours (no service availability outside routine business hours).

*Definitions do not need to be included on the complaint log.

Last revised: 05/01/2006

	Staffing Pattern	Complaint about insufficient staffing or high turnover with staff.
	Other - No Rights Violation	Catch all for generalized complaints that do not constitute a rights violation including consumer belief that they were not treated respectfully.
Financial	Fees/Co-pays	Concern relating to assessed fees and co-pays to the client for behavioral health services.
	Claims	Concerns by provider/insurance carrier regarding claims.
	Billing	Concerns by client/guardian that they have been inappropriately billed for services.
	Claim Payment	Concern of a provider relating to the payment for services (non-payment; incorrect payment; denial).
	Entitlements	Concern that a person is not receiving services because they do not fall into an entitled category (SMI, TXIX/XXI).
Information Sharing	Request for Medical Records	Concerns that client/guardian has requested, but not received, medical records.
	Family Involvement	Concerns that family members are not involved in treatment; families are concerned that they cannot get information about the enrolled client.
	Restrict Access to Health Information	Request to restrict access to health information.
f. Any identified communication need:		
Category		Definition*
NA		No special communication needs are identified.
Interpretation - Spanish		Requires Spanish interpretation to participate in the complaint process.
Interpretation - Other		Requires language interpretation (other than Spanish) to participate in the complaint process.
Visually Impaired		Requires additional assistance to participate in the complaint process due to visual impairment.
Hearing Impaired		Requires additional assistance to participate in the complaint process due to hearing impairment (e.g., Sign Language).
Possible Need for Special Assistance		Person about whom the complaint is placed is a person with Serious Mental Illness and the person appears to be: Unable or unwilling to communicate preferences for services; and/or Unable or unwilling to participate in service planning; and/or Unable or unwilling to participate in a grievance, appeal or an investigation process. The person's limitations must be due to: Cognitive ability; Intellectual capacity; Sensory impairment (the need to use American Sign Language, Braille or lip reading); Language barriers (the need of a person who is learning disabled to receive information compatible with their comprehension level); or Medical condition.

*Definitions do not need to be included on the complaint log.

Last revised: 05/01/2006

Request for Special Assistance	Person with Serious Mental Illness or Guardian requests special assistance because the person is: Unable or unwilling to communicate preferences for services; and/or Unable or unwilling to participate in service planning; and/or Unable or unwilling to participate in a grievance, appeal or an investigation process. The person's limitations must be due to: Cognitive ability; Intellectual capacity; Sensory impairment (the need to use American Sign Language, Braille or lip reading); Language barriers (the need of a person who is learning disabled to receive information compatible with their comprehension level); or Medical condition.
g. The outcome reached:	
Category	Definition*
Resolved	Used when the complaint issues have been resolved (i.e., client places complaint about lack of transportation to therapy; then transportation is coordinated and provided).
Transferred to Office of Grievance and Appeals (OGA)	Used when a call or written communication comes to DBHS and a determination is made that the person does not want to utilize the complaint process, but does want to speak with the Grievance and Appeals office.
Transferred to Office of Human Rights (OHR)	Used when a call or written communication comes to DBHS and a determination is made that the person is already assigned an advocate who is assisting with an issue, or the person is requesting an advocate.
Referred to Another Agency	Used when the issue or inquiry is not relevant to the Division of Behavioral Health Services, but the DBHS staff identifies the agency that has jurisdiction or that may otherwise be able to assist the person.
Closed with Plan of Correction	Used when the T/RBHA submits a plan detailing the actions they plan to take to address/resolve the complaint; DBHS assesses the plan as adequate, and a conclusion is drawn that monitoring the plan through completion is not required.
Closed without Merit	Used when information gathered from the RBHA identifies the complaint placed requires no action or correction.
Resolved without Client Satisfaction	Used when the complainant is not satisfied with the outcome of the complaint, but grievance and appeal processes are not applicable.
Referred to Appeal Process	Used when complaint is not resolved to satisfaction and client is referred to the grievance or appeals process.
h. The length of time for outcome (business days)	

*Definitions do not need to be included on the complaint log.

Last revised: 05/01/2006

i. Covered services category:	
Category	Subcategory
Behavioral Health Day Programs	Medical Day Program
	Supervised Day Program
	Therapeutic Day Program
Crisis Intervention Services	Crisis Services - Mobile
	Crisis Services - Phone
	Crisis Services - Stabilization
	Detoxification Services
Inpatient Services	Hospital
	Subacute Facility
	Residential Treatment Center
Medication Services	Laboratory, Radiology, and Medical Imaging
	Medical Management
	Electro-Convulsive Therapy
Rehabilitation Services	Skills Training
	Cognitive Rehabilitation
	Health Promotion
	Psychoeducational Services and Support to Maintain Employment
Residential Services	Level II Residential
	Level III Residential
	Mental Health Services NOS (Room and Board)
Support Services	Case Management
	Personal Care Services
	Home Care Training Family (Family Support)
	Self-Help/Peer Services (Peer Support)
	Therapeutic Foster Care Services
	Unskilled Respite Care
	Supported Housing
	Sign Language or Oral Interpretive Services
	Flex Funds
	Transportation
Treatment Services	Counseling and Therapy
	Assessment, Evaluation and Screening Services
	Other Professional
j. Treatment setting	
Arizona State Hospital	
Crisis Stabilization Unit	
Group Home (24 hour)	
Inpatient	

*Definitions do not need to be included on the complaint log.

Last revised: 05/01/2006

Outpatient
Not Applicable
PHF
In Region/Network Residential Treatment
Therapeutic Foster Home
Out of Region Residential Treatment
k. Behavioral health category
Child
Child, with SED
Adult, Non-SMI, substance abuse, either alcohol or drug
Adult, Non-SMI, with general mental health need
Adult, with SMI
Not Enrolled

*Definitions do not need to be included on the complaint log.

Last revised: 05/01/2006